STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G392	A. BUILDING _____ B. WING _____	R 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL SERVICES INC OF INDIANA	308 W MAIN ST SILVER LAKE, IN 46982

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This visit was for a post certification revisit (PCR) to the pre-determined full recertification and state licensure survey completed on 9/30/2011. Dates of Survey: November 3, and 4, 2011 Surveyor: Susan Eakright, Medical Surveyor III/QMRP Provider Number: 15G392 Facility Number: 000906 AIM Number: 100235160 Cardinal Services Inc. of Indiana was found to be in compliance with 42 CFR Part 483 Subpart I and 460 IAC 9 in regard to the post-certification revisit (PCR) to the recertification and state licensure survey. Quality review 11/17/11 by Suzanne Williams, RN	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.